Medicare Claims Processing Manual

Chapter 9 - Rural Health Clinics / Federally Qualified Health Centers

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(Rev. 371, 11-19-04)

10 - General Differences Between RHCs and FQHCs

(Rev. 1, 10-01-03)

A3-3642, A3-3643

10.1 - Rural Health Clinics (RHCs)

(Rev. 1, 10-01-03)

A3-3642B-E, B3-9200

Rural Health Clinics (RHCs) are clinics that are located in areas that are designated both by the Bureau of the Census as rural and by the Secretary of DHHS as medically underserved. RHCs have been eligible for participation in the Medicare program since March l, 1978. Services rendered by approved RHCs to Medicare beneficiaries are covered under Medicare effective with the date of the clinic's approval for participation. Covered services are described in the Medicare Benefit Policy Manual, Chapter 13.

10.2 - Federally Qualified Health Centers (FQHCs)

(Rev. 1, 10-01-03)

A3-3643, RHC-400B

The statutory requirements that FQHCs must meet to qualify for the Medicare benefit are in §1861(aa)(4) of the Social Security Act (the Act) and are described in the Medicare Benefit Policy Manual, Chapter 13.

FQHC services consist of services that are similar to those provided in rural health clinics (RHC) but also include preventive primary services, as described in Chapter 13 of the Medicare Benefit Policy Manual.

An RHC cannot be concurrently approved for Medicare as both an FQHC and an RHC. An entity that qualifies as an independent or provider-based FQHC is assigned an FQHC identification number in the provider number range 1800-1989.

10.3 - Claims Processing Jurisdiction for RHCs and FQHCs

(Rev. 1, 10-01-03)

A3-3642, B3-9200.1

RHCs and FQHCs bill the intermediary (FI) for RHC or FQHC services, on Form CMS-1450.

United Government Systems processes all claims from independent FQHCs. Provider-based FQHC claims are processed by the FI servicing the provider.

The FI servicing the provider processes provider-based RHC claims.

Claims processing jurisdiction for independent RHCs (i.e., those that are not part of a hospital, SNF, or HHA) is shared among regional FIs. See http://www.cms.hhs.gov/contacts/incardir.asp for a listing of RHC regional FIs.

If the entity decides to become a physician directed clinic instead of an RHC or FQHC, the entity will be paid for services under physician payment rules including billing to the carrier on Form CMS-1500.

If the RHC/FQHC continues an election to be paid under the Part B payment methodology, they should continue to use Form CMS-1500, and bill the carrier while that option is in effect. In such cases, the RHC/FQHC is not entitled to payment for any additional benefits provided under the FQHC benefit package.

20 - Method of Medicare Payment for RHC and FQHC Services

(Rev. 1, 10-01-03)

A3-3642, A3-3643, RHC-500, RHC-504

20.1 - Payment Rate for Independent and Provider Based RHCs and FQHCs

(Rev. 1, 10-01-03)

Payment to independent provider-based RHCs and FQHCs for covered RHC/FQHC services furnished to Medicare patients is made by means of an all-inclusive rate for each visit. (Prior to January 1, 1998, provider based RHCs were paid on a reasonable cost basis.) The encounter rate includes covered services provided by an RHC/FQHC physician, physician assistant, nurse practitioner, clinical nurse midwife, clinical psychologist, clinical social worker or visiting nurse; and related services and supplies. The rate does not include services that are not defined as RHC/FQHC services.

The term “visit” is defined as a face-to-face encounter between the patient and a physician, physician assistant, nurse practitioner, nurse midwife, visiting nurse, clinical psychologist, or clinical social worker during which an RHC/FQHC service is rendered. (See the Medicare Benefit Policy Manual, Chapter 13, for definitions of these personnel. See also the Medicare Benefit Policy Manual, Chapter 13, for conditions of coverage for visiting nurse services).

Encounters with more than one health professional and multiple encounters with the same health professionals which take place on the same day and at a single location constitute a single visit, except when one of the following conditions exist: (a) after the first

encounter, the patient suffers illness or injury requiring additional diagnosis or treatment; (b) the patient has a medical visit and a clinical psychologist or clinical social worker visit.

20.2 - Calculation of the Encounter "Per Visit" Rate

(Rev. 1, 10-01-03)

RHC-500, PM A-99-10

Provider based and independent RHCs/FQHCs must furnish their FI with information currently collected on the Medicare cost reporting form for independent FQHC/RHCs (Form CMS-222). This form contains the minimum statistical visit data and other information necessary to enable the FI to calculate a cost-per-visit, apply FQHC/RHC productivity standards, and apply the FQHC/RHC payment cap. Providers must identify all incurred costs applicable to furnishing covered clinic/center services. This includes RHC/FQHC direct costs, any shared costs applicable to the RHC/FQHC, and the RHCs/FQHCs appropriate share of the parent provider's overhead costs. Total RHC/FQHC costs applicable to furnishing covered RHC/FQHC services are to be included in the calculation of the RHC/FQHC cost-per-visit, using the methodology employed on the Form CMS-222 cost reporting forms and instructions.

If the RHC/FQHC is in the initial reporting period, the all-inclusive rate is determined on the basis of a budget the RHC/FQHC submits. The budget estimates the allowable cost to be incurred by the RHC/FQHC during the reporting period and the number of visits for RHC/FQHC services expected during the reporting period. RHCs/FQHCs supply this information using Form CMS-222-92.

In determining the payment rate for new RHCs/FQHCs and for those who have submitted cost reports, the FI applies screening guidelines and the maximum payment per visit limitation as described in §20.4.

For subsequent reporting periods, the all-inclusive rate is determined, at the discretion of the FI, on the basis of a budget or the prior year's actual costs and visits with adjustments to reflect anticipated changes in expenses or utilization.

20.3 - Calculation of Payment

(Rev. 1, 10-01-03)

RHC-500

The interim Medicare payments are based on the all-inclusive rate per visit established by the Medicare FI. The rate is paid, subject to the Medicare deductible and coinsurance requirements, for each covered visit with a Medicare beneficiary. No deductible applies to FQHC services provided at FQHCs. Only FQHC services are exempt from the deductible.

20.4 - Determination of Payment

(Rev. 1, 10-01-03)

RHC-500

The payment rate is calculated, in general, by dividing the total allowable cost by the number of total visits for RHC/FQHC services.

At the end of the reporting period, RHCs/FQHCs submit a report to the FI of actual allowable costs and actual visits for RHC/FQHC services for the reporting period. Also RHCs/FQHCs submit any other information as may be required. (See §30.5.) After reviewing the report, the FI divides actual allowable costs by the number of actual visits to determine a final rate for the period. Both the final rate and the interim rate are subject to screening guidelines for evaluating the reasonableness of the clinic's productivity, a payment limit, and psychiatric services limit as explained in §40.3, §20.6, and §60.

20.5 - Annual Reconciliation

(Rev. 1, 10-01-03)

RHC-500

At the end of the reporting period, the FI determines the total payment due and the amount necessary to reconcile payments made during the period with the total payment due. (See §30.)

20.6 - Maximum Payment Per Visit

(Rev. 1, 10-01-03)

RHC-505

20.6.1 - Rural Health Clinics

(Rev. 1, 10-01-03)

PM A-99-08, A-00-30

Section 1833(f) of the Act established the initial payment limit for RHC services provided from April 1, 1988 through December 31, 1988, at $46 per visit. For services furnished on or after January 1 of each subsequent year, the RHC payment limit is increased as of the first day of the year by the percentage increase in the Medicare Economic Index (MEI) applicable to primary care physician services. The MEI is defined in §1842(b)(3) and (i)(3) of the Act and 42 CFR 405.504(a)(3). The MEI percentage increase is updated annually, which yields a per visit payment limit that is also updated

annually. The CMS will formally update these numbers each year through a program memorandum.

Since §1833(f) of the Act provides that each payment limit applies to services provided during a calendar year, it is possible for different payment limits to apply during one reporting period. Medicare visits to which different payment limits apply and the resulting Medicare costs must be separately identified on Form CMS-222-92.

20.6.2 - Federally Qualified Health Centers

(Rev. 1, 10-01-03)

RHC-500

The FQHC payment methodology includes one urban and one rural payment limit. For services furnished on or after January 1 of each subsequent year, the FQHC payment limit is increased as of the first day of the year by the percentage increase in the Medicare Economic Index (MEI) applicable to primary care physicians services. CMS will formally review and update the payment limits annually via program memorandum.

An FQHC is designated as an urban or rural entity based on the urban and rural definitions in §1886(d)(2)(D) of the Act. If the FQHC is located within a Metropolitan Statistical Area (MSA) or New England County Metropolitan area (NECMA), then the urban limit applies. If the FQHC is not in an MSA or NECMA and cannot be classified as a large or other urban area, the rural limit applies. Rural FQHCs cannot be reclassified into an urban area (as determined by the Bureau of Census) for FQHC payment limit purposes.

Section 1833(f) of the Act provides that each RHC payment limit applies to services provided during a calendar year. Since the FQHC payment limit application is consistent with §1833(f) of the Act, it is possible for different payment limits to apply during one reporting period. Medicare visits to which different payments limits apply and the resulting Medicare costs must be separately identified on Form CMS-222-92.

20.6.3 - Exceptions to Maximum Payment Limit (Cap) in Encounter Payment Rate for Provider-Based RHCs

(Rev. 1, 10-01-03)

All RHCs based in hospitals with less then 50 beds are eligible to receive an exception to the per visit payment limit.

From January 1, 1998 through June 30 2001, this exemption was limited to rural hospitals with less than 50 beds. Rural hospitals are those hospitals not located in a metropolitan statistical area as defined by 42 CFR 412.62(f)(1)(ii)(A).

This exception to the payment limit does not apply to provider-based FQHCs. Similarly, there is no exception available for independent RHCs or FQHCs.

To determine number of beds, use the definition in 42 CFR 412.105(b) to determine the number of beds for the current cost reporting period.

A hospital-based RHC can also receive an exception to the per visit payment limit if its hospital has an average daily patient census that does not exceed 40 and the hospital meets the following conditions: (a) It is a sole community hospital. (b) It is located in an 8-level or 9-level nonmetropolitan county using urban influence codes as defined by the U.S. Department of Agriculture.

20.7 - Special Rules for FQHC Networks

(Rev. 1, 10-01-03)

RHC-505.3

An FQHC network consists of a group of two or more FQHCs that are owned, leased, or through any other device, controlled by one organization. FQHCs that are part of networks have the option to file either a single consolidated cost report for the entire network or separate cost reports for each site within the network.

20.7.1 - Separate Payment Limits for Individual Cost Reports

(Rev. 1, 10-01-03)

RHC-505.3.A

If an FQHC network chooses to file individual cost reports for each site, then they are paid the lower of their specific all-inclusive rate or their appropriate payment limit for each site. The appropriate payment limit depends on the geographic designation (either urban or rural). The home office must allocate costs that are applicable to individual sites appropriately to each site within the network. These allocations are subject to FI review and are included in the respective encounter rates.

20.7.2 - Consolidated Payment Limit for Networks Having Mixture of Urban and Rural Sites

(Rev. 1, 10-01-03)

RHC-505.3.B

If the network includes both urban and rural sites, the FQHCs are paid the lower of the network all-inclusive rate or a single weighted payment limit calculated for the entire network. The payment limit is weighted by the percentage of urban and rural visits as a percentage of total visits for the entire FQHC network. The urban payment limit is

weighted by the percentage of visits attributed to urban sites and the rural payment limit is weighted by the percentage of visits attributed to rural sites.

A weighted calculation based on the 1991 urban limit of $72.39 and rural limit of $62.25 is illustrated below. This FQHC network illustration contains three urban sites and two rural sites.

FQHC Site	Limit Adjusted By Percent of Total Visits
Urban Site #1	25% of total network visits
Urban Site #2	22% of total network visits
Urban Site #3	18% of total network visits
Total Urban Limit Component	65% x $72.39 = $47.05
Rural Site #1	20% of total network visits
Rural Site #2	15% of total network visits
Total Rural Limit Component	35% x $62.25 = $21.79
Weighted Limit	$47.05 (Urban Weight)
	+$21.79 (Rural Weight)
	$68.84

The 1991 weighted FQHC payment limit for this example is $68.84. The entire network is paid the lower of the urban/rural network weighted payment limit or the network all-inclusive rate (total costs divided by visits) for each covered visit.

The annual adjustment is applied to the urban and rural payment limits prior to the network single weighted payment limit calculation.

20.7.3 - Consolidated Payment Limit for FQHC Networks With All Urban or All Rural Sites

(Rev. 1, 10-01-03)

RHC-505.3.C

If the network includes **all urban or all rural** sites, the FQHC is paid the lower of the network all-inclusive rate or the applicable network urban/rural payment limit. The consolidated weighted payment limit calculation is applicable only to networks with a mixture of both urban and rural sites.

30 - Annual Reconciliation With Cost Report

(Rev. 1, 10-01-03)

RHC-506

30.1 - Submission of Cost Report

(Rev. 1, 10-01-03)

RHC-506

On or before the last day of the fifth month following the close of RHC/FQHC reporting period, the RHC/FQHC must submit to its FI a cost report showing the actual costs incurred and the total number of visits for RHC/FQHC services the period. Using this information, the FI determines the total payment amount due for covered services furnished to Medicare beneficiaries.

30.2 - Payment Reconciliation

(Rev. 1, 10-01-03)

RHC-506.1

The FI compares the total payment due with the total payments made for services furnished during the reporting period. If the total payment due exceeds the total payments made, the RHC/FQHC has been underpaid. The underpayment is made up by a lump sum payment.

If the total payment due is less than the total payments made, the RHC/FQHC has been overpaid for services furnished to Medicare patients. Methods for recovery of overpayment are discussed in §30.4.

30.3 - Notice of Program Reimbursement

(Rev. 1, 10-01-03)

RHC-506.2

When the FI determines the total reimbursement due and the amount of any overpayment or underpayment, it gives the RHC/FQHC a written notice of program reimbursement (NPR). The NPR sets out the FI's determination of the total payment due and the amount of any overpayment or underpayment. The notice also advises the RHC/FQHC appeal rights if it should disagree with the determination. See Chapter 29 for a complete discussion of claim appeals procedures

30.4 - Recovery of Overpayments

(Rev. 1, 10-01-03)

RHC-506.3

Once a determination of overpayment has been made, the amount so determined is a debt owed to the United States Government.

When the NPR is received stating the amount of the overpayment, the RHC/FQHC is required to immediately make a lump sum refund to the FI. If the RHC/FQHC is unable to make a lump sum refund, it may work out arrangements with the FI for recovery through an extended repayment schedule. Generally, the period of recovery is not to exceed 12 months from the date of the NPR. If, however, the RHC/FQHC demonstrates that repayment within the 12-month period creates a financial hardship, the period for recoupment may be extended.

30.5 - Reporting Requirements for Cost Report

(Rev. 1, 10-01-03)

RHC-507

The RHC/FQHC must maintain and provide adequate cost data based on financial and statistical records that can be verified by qualified auditors. The data must be maintained on the accrual basis of accounting. However, a government institution that operates on a cash basis of accounting may maintain data other than capital expenditure data on a cash basis.

If records are maintained on a cash basis, RHCs/FQHCs need adjust only a relatively few items from the cash basis to an accrual basis at the end of the reporting period to meet the accrual requirement. These adjustments need not be recorded in formal accounting records. It is acceptable for these adjustments to be made in supplementary records. These adjustments are necessary, for example, if expenses are prepaid, if expenses are incurred in one reporting period and paid in a later period, supplies are bought in one period for use during later periods, or capital assets are expensed instead of depreciated.

Cost information must be current, accurate and in sufficient detail to support payments made for services rendered to Medicare beneficiaries. This includes all ledgers, records and original evidences of cost (e.g., purchase requisitions, purchase orders, invoices, vouchers, payroll vouchers) that pertain to the determination of reasonable cost. Financial and statistical records must be maintained in a consistent manner from one period to another.

30.5.1 - Definitions

(Rev. 1, 10-01-03)

RHC-507.B

Accrual Basis of Accounting - Revenue and expense are identified with specific periods of time (such as a month or year) to which they apply regardless of when revenue is received or disbursement made for expenses.

Cash Basis of Accounting - Revenue and expense are recorded on the books of account when they are received and paid, respectively, without regard to the period to which they apply.

Government Institution - This is an RHC/FQHC owned and operated by a Federal, State or local government agency.

30.6 - When to Submit Cost Reports

(Rev. 1, 10-01-03)

RHC-508

The RHC/FQHC must submit an annual report covering a 12-month period of operations based upon its reporting period. (The first and last reporting periods may be less than 12 months.) RHCs/FQHCs select any annual period for Medicare reporting purposes, but this reporting period is subject to approval by the FI. Once RHCs/FQHCs have selected a reporting period and have obtained the approval of the FI, they must adhere to the period initially selected unless a change has been authorized in writing by the FI. Such a change is made only after the FI has established that the reason for such a change is valid. For detailed explanation of Cost Reporting Periods, see Medicare Provider Reimbursement Manual (PRM) 15-II, Chapter 1, §102. For a detailed explanation of Cost Report Due Dates see PRM 15-II, Chapter 1, §104.

If RHCs/FQHCs do not furnish any covered services to Medicare beneficiaries or where RHCs/FQHCs have low utilization of covered services by Medicare beneficiaries during the entire cost reporting period, RHCs/FQHCs do not need to file a full cost report to comply with the program cost reporting requirements. For a detailed explanation of the conditions under which less than full cost report may be filed, see PRM 15-II, Chapter 1, §110. Also, see §110 for an explanation of what is to be filed to comply with the cost reporting requirements for a “No Utilization Cost Report” or a “Low Utilization Cost Report.”

NOTE: While some providers, particularly pediatric centers, may not provide services to Medicare beneficiaries, they should still file a complete and full cost report to ensure that the appropriate increase to their interim rate is made.

30.7 - Penalty for Failure to File Cost Reports Timely

(Rev. 1, 10-01-03)

RHC-508.C

Failure to submit cost reports within the time frames specified previously may result in a reduction or suspension of payments.

Failure to submit cost reports may result in the treatment of all previous payments made during the current reporting period as overpayments.

30.8 - Filing Consolidated Worksheets Rather Than Individual Cost Reports

(Rev. 1, 10-01-03)

RHC-508.D

If RHCs/FQHCs are part of the same organization with one or more RHCs/FQHCs, they may elect to file consolidated worksheets rather than individual cost reports. Under this type of reporting, each RHC/FQHC in the organization need not file individual cost reports. Rather, the group of RHCs/FQHCs may file a single report that accumulates the costs and visits for all RHCs/FQHCs in the organization. In order to qualify for consolidation reporting, all RHCs/FQHCs in the group must be owned, leased, or through any other device, controlled by one organization.

RHCs/FQHCs make the election to file consolidated worksheets in advance of the reporting period for which the consolidated report is to be used. Once having elected to use a consolidated cost report, the RHC/FQHC may not revert to individual reporting without the prior approval of the FI.

40 - Allowable Costs

(Rev. 1, 10-01-03)

RHC-501

Allowable costs are the costs actually incurred by the RHC/FQHC that are reasonable in amount and necessary and proper to the efficient delivery of services.

The allowability of costs is governed by the applicable Medicare principles of reimbursement for provider costs as set forth in 42 CFR 413 and the PRM. These are the general Medicare principles that define allowable costs of hospitals and other facilities paid on a reasonable cost or cost related basis. The lesser of cost or charges principal does not apply to independent and provider-based RHCs and FQHCs. For a detailed explanation of the reimbursement policy concerning allowable cost see PRM 15-I.

Typical allowable costs include, to the extent reasonable:

- Compensation for the services of physicians, physician assistants, nurse practitioners, nurse midwives, clinical psychologists, and clinical social workers compensated by the RHC/FQHC;
- Compensation for the duties that a supervising physician is required to perform;
- Costs of services and supplies incident to the services of a physician, physician assistant, nurse practitioner, nurse midwife, clinical psychologist, or clinical social worker;
- Overhead costs, including RHC/FQHC administration, costs applicable to the use and maintenance of the RHC/FQHC facility, and depreciation costs;
- The costs of physician services furnished under agreements with the RHC/FQHC; and
- If the RHC/FQHC is located in an area with a shortage of home health agency (HHA) services, the cost of visiting nurse services and related supplies furnished.

40.1 - Costs Excluded from Allowable Costs

(Rev. 1, 10-01-03)

RHC-501.1

Items and services not covered under the Medicare program, e.g., dental services, eyeglasses, and routine examinations are not allowable. Preventive primary physical examinations targeted to risk are allowable at FQHCs.

Items and services that are covered under Part B of Medicare, but are not included in the definition of RHC/FQHC services, e.g., routine diagnostic and laboratory services, independent laboratory services, durable medical equipment, and ambulance services are not allowable on the cost report. However, the provider of these services may bill for these items separately.

40.2 - Allowable Costs Subject to Tests of Reasonableness

(Rev. 1, 10-01-03)

RHC-502

Allowable costs are limited to amounts that are reasonable. The CMS has established screening guidelines which FIs use to test the reasonableness of an RHC/FQHCs productivity and a payment limit which the per visit rate may not exceed. Costs for which screening guidelines have not been established by CMS are disallowed to the extent the FI determines they are unreasonable.

40.3 - Screening Guidelines of RHC/FQHC Health Care Staff Productivity

(Rev. 1, 10-01-03)

RHC-503

Payments for services are subject to guidelines to test the reasonableness of the productivity of the clinic/center's health care staff. These guidelines are applied to staff for RHC/FQHC services furnished both at the clinic/center's site and in other locations. They are as follows:

- At least 4,200 visits per year per full time equivalent physician employed by the clinic/center;

- At least 2,100 visits per year per full time equivalent physician assistant or nurse practitioner employed by the clinic/center; or

- If staffing levels consist of various combinations of physicians and nurse practitioners or physician assistants, a combined screening approach may be used. For example, if a clinic/center has three physicians and one nurse practitioner, calculate the screening guidelines as follows:

  3 x 4,200 = 12,600;

  1 x 2,100 = 2,100 (12,600 + 2,100 = 14,700).

  Another example is a clinic/center with four nonphysician practitioners (4 x 2,100 = 8,400).

- The number of full time equivalent employees (FTE) of each type (i.e., physician, physician assistant, or nurse practitioner) is determined by the following formula. Divide the total number of hours per year worked by all employees of that type by the greater of:

- The number of hours per year for which one employee of that type must be compensated to meet the clinic/center's definition of an FTE. (If the clinic/center is open on a full time basis, the usual definition of an FTE is 2,080 hours per year, 40 hours per week for 52 weeks); or

- 1,600 hours per year (40 hours per week for 40 weeks).

FIs may waive the productivity guideline in cases in which a clinic/center has demonstrated reasonable justification for not meeting the standard. In these cases in which an exception is granted, the FI, no longer restricted by the number of actual visits, sets the number of visits that it determines is reasonable. For example, the guideline number is 4,200 visits, and the clinic/center has furnished only 1,000 visits. The FI does

not accept the 1,000 visits as reasonable but permits 2,500 visits to be used in the calculation.

40.4 - All Inclusive Rate of Payment

(Rev. 1, 10-01-03)

RHC-504, A3-3628

Payments to RHCs/FQHCs for covered RHC/FQHC services furnished to Medicare beneficiaries are made on the basis of an all-inclusive rate per covered visit (except for pneumococcal and influenza vaccines and their administration, which are paid at 100 percent reasonable cost). The term "visit" is defined as a face-to-face encounter between the patient and a physician, physician assistant, nurse practitioner, nurse midwife, clinical nurse midwife, visiting nurse, clinical psychologist, or clinical social worker during which an RHC/FQHC service is rendered. (See the Medicare Benefit Policy Manual, Chapter 13, for definitions of these personnel.) Encounters with more than one health professional and multiple encounters with the same health professional which take place on the same day and at a single location constitute a single visit, except for cases in which the patient, subsequent to the first encounter, suffers an illness or injury requiring additional diagnosis or treatment or the patient has a medical visit and a mental health visit. Mental health visit means a face-to-face encounter between an RHC/FQHC patient and a clinical psychologist or clinical social worker.

40.5 - Bad Debts

(Rev. 1, 10-01-03)

RHC-504.1A

RHCs/FQHCs are allowed to claim bad debts in accordance with 42 CFR 413.80. For FQHCs, bad debts are limited to Medicare coinsurance amounts that remain unpaid by the Medicare beneficiary since no deductible is applied to FQHC services. RHCs may claim unpaid deductible also. The RHC/FQHC must establish that reasonable efforts were made to collect these coinsurance amounts in order to receive payment for bad debts. When either waives coinsurance or deductible (RHC) it may not claim bad debt amounts for which it assumed the beneficiary's liability.

40.6 - Calculation of Medicare Program Payment

(Rev. 1, 10-01-03)

RHC-500.B

RHC/FQHC's interim Medicare payments are based on the all-inclusive rate per visit established by the FI. The rate is paid, subject to the Medicare deductible and coinsurance requirements, for each covered visit with a Medicare beneficiary. No deductible applies

to FQHC services provided at FQHCs. Only FQHC services are exempt from the deductible.

40.7 - Determination of Payments

RHC-500.C

The payment rate is calculated, in general, by dividing total allowable cost by the number of total visits for RHC/FQHC services. An interim rate is determined at the beginning of the reporting period on the basis of RHC/FQHC's estimated allowable costs and estimated visits for RHC/FQHC services, as reported on the Independent Rural Health Clinic/Freestanding Federally Qualified Health Center Worksheets, Form CMS-222-92.

The facility is paid this rate the following year minus any coinsurance and/or deductible reported on the claim.

This rate may be adjusted during the reporting period at the FI's discretion.

50 - Deductible and Coinsurance

(Rev. 1, 10-01-03)

RHC-504.1

50.1 - Part B Deductible

(Rev. 1, 10-01-03)

RHC-500.B

In each calendar year, a cash deductible must be satisfied before payment can be made under supplementary medical insurance (SMI). Currently, the cash deductible is $100; this amount is subject to change.

Bills count toward the deductible on the basis of incurred, rather than paid, expenses. For RHC/FQHC services deductible is based on billed charges. Noncovered expenses do not count toward the deductible. Even though an individual is not eligible for the entire calendar year, i.e., his/her insurance coverage begins after the first month of the year or he/she dies before the last month of the year, he/she is still subject to the full Part B cash deductible. Medical expenses incurred in any portion of the year preceding entitlement to SMI are not credited toward the Part B deductible.

The Part B deductible does not apply to FQHC services. It does apply to non-FQHC services billed to the carrier or FI and to RHC services.

Deductible for non-RHC/FQHC services billed by the parent provider is based on rules for the host provider.

50.2 - Part B Coinsurance

(Rev. 1, 10-01-03)

RHC-500.B

After the deductible has been satisfied, RHCs will be paid 80 percent of the all-inclusive interim encounter payment rate. The patient is responsible for a coinsurance amount of 20 percent of the charges after deduction of the deductible. Note that 20 percent of charges may not be equal to 20 percent of the encounter rate, e.g., if the charges are not equal to the encounter rate.

On claims to the carrier, e.g., independent RHC/FQHC claims for non-RHC/FQHC services, coinsurance is established based on 20 percent of the allowed amount.

On provider based RHC/FQHC claims for non-RHC/FQHC services coinsurance is based on the rules applicable to the parent provider type and the type of service.

60 - Mental Health Services Limit

(Rev. 1, 10-01-03)

RHC-612, RHC-613, A3-3185

60.1 - Definition of Mental Health Services in RHC/FQHC

(Rev. 1, 10-01-03)

RHC-419.2.C

Mental, psychoneurotic, and personality disorders are defined as the specific psychiatric conditions described in the American Psychiatric Association's "Diagnostic and Statistical Manual-Mental Disorders." The mental health payment limitation applies to expenses incurred in connection with one of these psychiatric conditions. It is applicable to physicians' services or items and supplies furnished by physicians. No distinction is made when applying the limitation between the services of psychiatrists and nonpsychiatric physicians. Therapeutic services furnished by other health practitioners are subject to the mental health treatment limitation when rendered in connection with a condition included in the definition of "mental, psychoneurotic, and personality disorders."

Charges for initial diagnostic services (i.e., psychiatric testing and evaluation used to diagnose the patient's illness) are not subject to this limitation. The limitation is applied only to therapeutic services.

Thus, the following types of diagnostic services would be exempt from the limitation:

- Psychiatric testing - this refers to use of actual testing instruments such as intelligence tests;
- Psychiatric consultations - evaluation made by a physician or non-physician for purposes of preparing a report for the attending physician; or
- Initial psychiatric visits - evaluation made by a physician who will test the patient

60.2 - Application of Limit

(Rev. 167, 04-30-04)

RHC-613, A3-3185.1

The beneficiary is responsible for at least 37.5 percent of the all-inclusive rate for psychiatric therapy services. Additionally, the beneficiary is responsible for the coinsurance and any unmet deductible (for RHCs only) that is based on the remaining 62.5 percent of the reasonable charges. Therefore, the patient's liability is a two-part calculation as follows:

Part 1 - 62.5% limitation:

1. Multiply the charges for revenue code 0900 by 37.5%.

Part 2 - Deductible and coinsurance calculation:

1. Multiply charges for revenue code 0900 by 62.5% to calculate recognized charges.
2. For RHCs, apply any portion of recognized charges necessary toward the deductible, if it is applicable and has not yet been fully satisfied. For FQHCs, there is no deductible obligation; therefore, this step is not applicable.
3. Multiply remaining recognized charges by 20% to calculate coinsurance.

Total beneficiary liability for RHCs is 37.5 percent of revenue code 0900 charges plus 20 percent of recognized charges (coinsurance) plus any unmet deductible (as calculated from recognized charges.)

Total beneficiary liability for FQHCs is 37.5 percent of revenue code 0900 charges plus 20 percent of recognized charges (coinsurance.)

Use the following computation to determine Medicare payment for FQHCs and for RHCs when the deductible has already been completely satisfied or will be completely satisfied by the current claim. The computation for Medicare payment is as follows:

1 - Subtract the 37.5 psychiatric liability (plus for RHCs any amount applied toward the deductible) from the clinic's/center's all-inclusive payment rate.

2 - Multiply the remainder by 80%.

The following examples illustrate how payment is made to a clinic and how beneficiary liability is computed for the outpatient psychiatric limitation for RHC services.

Assume the deductible is $100 for the following examples:

EXAMPLE A

Total outpatient mental health limit amount for therapy is $60.00. The all-inclusive rate is $48.00. No part of the deductible has been met. In this instance, the RHC total charges are applied to the beneficiary deductible. The beneficiary's liability is the full $60 and $37.50 is applied toward the deductible (62.5 percent of $60).

Medicare makes no payment to the RHC/FQHC.

EXAMPLE B

Total outpatient mental health limit amount for therapy is $64. The RHC all-inclusive rate is $48. Thirty-seven dollars and fifty cents is applied toward the deductible from example A

The computation for patient liability is as follows:

Part 1: $64 X 37.5% = $24.

Part 2: $64 X 62.5% = $40, which is applied to the deductible.

No Medicare payment can be made since only $77.50 of the deductible has been met. The beneficiary is liable for the full $64 charges.

EXAMPLE C

Total outpatient mental health limit amount for therapy is $48. The RHC all-inclusive rate is $48. The beneficiary deductible is credited with $77.50.

The computation for patient liability is as follows:

Part 1:	$48 X 37.5%	= $18.
Part 2:	$48 X 62.5%	= $30. $22.50 is applied to the deductible. $7.50 X 20% = $1.50 coinsurance. Total beneficiary liability = $18 (Part 1) plus $22.50 (deductible) plus $1.50 (coinsurance) = $42.00.

The computation for Medicare payment is as follows:

The all-inclusive rate minus the beneficiary liability of $42.00 leaves $6.00 to be paid to the clinic.

EXAMPLE D

Total outpatient mental health limit amount for therapy is $40. Ninety dollars of nonpsychiatric expenses had previously been incurred and applied to the deductible. The RHC all-inclusive rate is $48.

The computation for patient liability is as follows:

Part 1	$40 X 37.5%	= $15.00
Part 2	$40 X 62.5%	= $25.00.
		$10 of deductible remains to be met.
		$25.00 - $10.00 X 20% = $3.00 coinsurance.
		Total beneficiary liability = $15.00 + $10 + $3.00 = $28.00.

The computation for Medicare payment is as follows:

The all-inclusive rate of $48.00 minus the beneficiary liability of $28.00 leaves $20.00 Medicare payment to the clinic.

70 - Determining How Much to Charge Patient Before Billing Is Submitted for Part B Payment

(Rev. 1, 10-01-03)

RHC-608

RHCs/FQHCs should ask the patient for any evidence that he/she has met the deductible, such as a Medicare Summary Notice. They may take into account any other available information of the patient’s deductible status, such as its billing history records.

Where the deductible is met for RHCs collect no more than 20 percent of the charges. For RHC services where the deductible is known to be met in part, no more than the unmet deductible and 20 percent of the remaining charge may be collected. When the deductible is not met or its status is unknown, collect no more than the cash deductible and 20 percent of the balance. Once RHCs have billed the FI for services, they do not collect or accept any additional money from the patient for such services until the FI notifies the RHC of how much of the deductible has been met.

For FQHC services, the Part B deductible does not apply. Collect no more than 20 percent of the charges.

100 - General Billing Requirements

(Rev. 371, Issued 11-19-04, Effective: 04-01-05, Implementation: 04-04-05)

General information on basic Medicare claims processing can be found in this manual in:

- *Chapter 1, "General Billing Requirements," (http://www.cms.hhs.gov/manuals/104_claims/clm104c01.pdf) for general claims processing information;*

- Chapter 2, *"Admission and Registration Requirements,"* (*http://www.cms.hhs.gov/manuals/104_claims/clm104c02.pdf*) for general filing requirements applicable to all providers.

For Medicare institutional claims:

- *See Chapter 25 "Completing and Processing UB-92 Data Set" (http://www.cms.hhs.gov/manuals/104_claims/clm104c25.pdf) for general requirements for completing the institutional claim data set (paper, flat file, and HIPAA Version (837)).*

NOTE: *Chapter 25 lists all revenue codes available. However, RHC/FQHC is limited to the revenue codes listed in B-Service Level Information, below.*

Additionally, see §10.3 *in this chapter* for jurisdiction *of RHC/FQHC* claims.

- General *Medicare institutional claims processing* requirements, such as for timely filing and payment, admission processing, Medicare Summary Notices, and *required claim* data elements are applicable to RHCs and FQHCs.

- *Any institutional provider, including RHCs/FQHCs, should contact their fiscal intermediary (FI) for basic training and orientation material if needed.*

The focus of this chapter is RHCs/FQHCs, meaning only institutional claims using TOBs 71x and 73x, not any other provider or claim types. Professional claims, completed by

physicians and non-institutional practitioners, are sent to Medicare carriers on Form CMS-1500 or 837 HIPAA professional claim.

Generally, it is only services that are part of the RHC or FQHC benefit that are billed on these claims, and there are limited services provided under this benefit. The RHC/FQHC benefit provides specific primary or professional medical services, equivalent to certain physician or practitioner services, to Medicare beneficiaries in underserved or specially designated areas receiving specific types of grants or funding.

- *The RHC/FQHC benefit is defined in Pub. 100-02, Medicare Benefit Policy Manual, Chapter 13 (http://www.cms.hhs.gov/manuals/102_policy/bp102c13.pdf.)*

The core services of the benefit are professional, meaning the hands-on delivery of care by medical professionals. However, some preventive services are also encompassed in primary care under the benefit, and these services may have a technical component, such as a laboratory service or use of diagnostic testing equipment. For FQHCs only: Certain mandated preventive services include a laboratory test that is included in the FQHC encounter rate. (See CFR 42 405.2446 (b)(9) and 405.2448 (b) and the RHC/FQHC specific billing instructions in A and B, below.) ***In general, if NOT part of the RHC/FQHC benefit, technical services, or technical components of services with both professional and technical components, are not billed on RHC/FQHC claims****.*

All services in the benefit are reimbursed through a single all-inclusive rate paid for each patient encounter or visit. The encounter rate includes covered services provided by an RHC/FQHC physician, physician assistant, nurse practitioner, clinical nurse midwife, clinical psychologist, clinical social worker or visiting nurse; and related services and supplies. The rate does not include services that are not defined as RHC/FQHC services.

The term "visit" is defined as a face-to-face encounter between the patient and a physician, physician assistant, nurse practitioner, nurse midwife, visiting nurse, clinical psychologist, or clinical social worker during which an RHC/FQHC service is rendered. These services are reimbursed by the Medicare Part B trust fund. RHC services are subject to the Medicare coinsurance and deductible rules. FQHC services are subject to the Medicare coinsurance rules but are not subject to the Medicare deductible rules.

A. Claim-Level Information

RHCs or FQHCs bill to FIs on institutional claims, either on the UB-92/Form CMS-1450, or the 837 institutional claim, using type of bill (TOB) 71x for RHC, and 73x for FQHC.

The following rules apply *specifically* to all RHC/FQHC claims:

- Bill types 71x and 73x *MUST be used on institutional claims* for RHC/FQHC *benefit* services for *BOTH* independent and provider-based facilities.

- *The third digit of TOBs 71x and 73x provides additional information regarding the individual claim. When the third digits, called frequency codes are used on RHC/FQHC claims the TOBs are:*
    - *710 or 730 = non-payment/zero claim (a claim with only noncovered charges, beneficiary liable)*
    - *711 or 731 = Admit through discharge (original claim)*
    - *717 or 737 = Replacement of prior claim (adjustment)*
    - *718 or 738 =Void/cancel prior claim (cancellation)*

NOTE: *"x" represents a digit that can vary.*

- *RHC/FQHC claims cannot overlap calendar years. Therefore, the statement dates, or from and through dates of the claim, must always be in the same calendar year, and periods of billing ranging over 2 calendar years must be split into 2 separate claims for the 2 different calendar years.*
- *RHC/FQHC TOB 71x/73x claims are defined as outpatient institutional claims under HIPAA and should follow those guidelines.*

B. Service-Level Information

Only three types of services are billed on TOBs 71x and 73x:

- *Professional or primary services not subject to the psychiatric limit bundled into line item(s)using revenue code 052x;*
- *Services subject to the psychiatric limit under revenue code 0900*; and*
- *Telehealth originating site facility fees under revenue code 0780.*

All charges are entered in the following revenue code lines:

- *052x – FreeStanding Clinic; or*
- *0900* – Behavioral Health Treatment/Services, General Classification; and/or*
- *0780 –Telemedicine, General Classification.*

NOTE: *Telehealth is not an RHC/FQHC service. As such, the originating site facility fee is billed in addition to the appropriate encounter billed in revenue code 052x or 0900.*

Revenue code 052x, "Freestanding Clinic", is used to bill all professional services, not subject to the psychiatric limit, under the RHC/FQHC benefit, in the encounter bundle.

- *Values for the fourth digit of revenue code 052x are:*
    - *0520 = Freestanding Clinic – to be used by all FQHCs;*
    - *0521 = Rural Health Clinic – to be used by RHCs clinics; and*
    - *0522 = Rural Health Home – to be used by RHCs in home settings.*

Revenue code 0900 ("Behavioral Health Treatments/Services, General Classification") is used for services subject to the psychiatric limit *on claims with dates of service on or after October 16, 2003, that are received on and after October 1, 2004; for claims received before October 1, 2004, and for all claims with dates of service before October 16, 2003, use revenue code 0910 ("Behavioral Health Treatments/Services-Extension of 0900, Reserved for National Use", formerly "Psychiatric/ Psychological Services, General Classification") instead.*

- *All fourth digits for this revenue code may be valid on RHC/FQHC claims; the value that best represents the service should be used.*
- *All revenue codes are listed in Chapter 25, mentioned above (http://www.cms.hhs.gov/manuals/104_claims/clm104c25.pdf).*

Revenue code 0780 ('Telemedicine, General Classification") is used to bill for the telehealth originating site facility fee. Telehealth originating site facilities' fees billed using revenue code 0780 are the only line items allowed on TOBs 71x/73x that are NOT part of the RHC/FQHC benefit.

- *These line items require use of HCPCS code Q3014 in addition to the revenue code (0780) to indicate the facility fee is being billed.*
- *These are the only services billed on TOB 73x that will be subject to the Part B deductible.*
- *See chapter 15, §270 of Pub. 100-02, Medicare Benefit Policy Manual, (http://www.cms.hhs.gov/manuals/102_policy/bp102c15.pdf) for definition of telehealth services.*

For dates of service from January 1, 2002 through March 31, 2005, HCPCS codes were required for selected screening and preventive services. For details, see chapter 18 of this manual (http://www.cms.hhs.gov/manuals/104_claims/clm104c18.pdf). Additionally, Independent FQHC services were billed using one of five HCPCS codes, and hospital-based FQHC services were billed with one of a series of HCPCS codes. Those HCPCS codes are 99201-99205 and 99211-99215. Effective with dates of service on and after April 1, 2005 FQHCs/RHCs are no longer required to use HCPCS codes when billing for RHC/FQHC services. Charges are only entered on the revenue code line.

- *See chapter 1, §60 (http://www.cms.hhs.gov/manuals/104_claims/clm104c01.pdf) of this manual for information on* billing noncovered charges or claims to FIs;

- *Line items on outpatient claims under HIPAA require reporting of a line-item service date for each iteration of each revenue code. A single date should be reported on a line item for the date the service was provided, not a range of dates. Most if not all RHC/FQHC services are provided on a single day.*

    - *For services that do not qualify as a billable encounter, the usual charges for the services are added to those of the appropriate (previous or subsequent) encounter. RHCs/FQHCs use the date of the encounter as the single date on the line item.*

- Units are reported based on encounters, *which are paid the all-inclusive rate no matter how many services are delivered.* Only one encounter is *billed* per day unless the patient leaves and later returns with *a different* illness or impairment suffered later on the same day *(and medical records should support these cases).* Units for encounters are to be reported under revenue codes *0900 (0910 depending on the date) or 052x*, as applicable.

- *No type of technical services, such as a laboratory service, or technical component of a diagnostic or screening service, is **ever billed** on TOBs 71x or 73x. Technical services specifically included in this benefit or expressly applicable to the 71x/73x TOBs in other instructions are bundled into the encounter rate. Consequently they are not separately identified on the claim.*

If technical services/components not part of the benefit are performed in association with professional services or components of services billed on 71x/73x claims, how the technical services/components are billed depends on whether the RHC/FQHC is independent or provider-based:

    - *Technical services/components associated with professional services/components performed by **independent RHCs/FQHCs** are billed to Medicare carriers on professional claims (Form CMS-1500 or 837P.) See chapters 12 (http://www.cms.hhs.gov/manuals/104_claims/clm104c12.pdf) and 26 (http://www.cms.hhs.gov/manuals/104_claims/clm104c26.pdf) of this manual for billing instructions.*

    - *Technical services/components associated with professional services/components performed by **provider-based RHCs/FQHCs** are billed by the base-provider on the applicable TOB and submitted to the FI; see the applicable chapter of this manual based on the base-provider type, such as chapter 3 (*http://www.cms.hhs.gov/manuals/104_claims/clm104c03.pdf*) for inpatient hospital claims, chapter 4 (*http://www.cms.hhs.gov/manuals/104_claims/clm104c04.pdf*) for outpatient hospital, chapter 6*

*(*http://www.cms.hhs.gov/manuals/104_claims/clm104c06.pdf*) for inpatient SNF, chapter 7 for Outpatient SNF, etc.*

The following *three* sections describe other billing rules applicable to RHC and FQHC claims *or services*.

110 - Special FQHC Requirements

(Rev. 371, Issued 11-19-04, Effective: 04-01-05, Implementation: 04-04-05)

Effective April 1, 2005 FQHCs need not report HCPCS codes for FQHC services. *For earlier dates some requirements to report HCPCS codes apply. For details on these requirements, see the following two subsections.*

110.1 - Reporting of Preventive Services in the FQHC Benefit by Independent FQHCs

(Rev. 371, Issued 11-19-04, Effective: 04-01-05, Implementation: 04-04-05)

A. Claims with Dates of Service on or After April 1, 2005

Preventive services that are part of the FQHC benefit no longer require HCPCS codes. These services are included in the encounter bundle billed under revenue code 0520.

> ***NOTE:*** *However, though HCPCS code 90749 is no longer required, a visit is not billed if an immunization is the only service the FQHC provides. See instructions in §100B - Service Level Information, above.*

B. Claims with Dates of Service Before April 1, 2005

For claims submitted by independent FQHCs with dates of service before April 1, 2005, Medicare instructions to FIs required HCPCS code reporting for specific preventive services that are part of the FQHC benefit as follows:

a - Preventive Medicine Evaluation and Service Management

Covers services related to a physical exam, history, and interventional counseling. Independent FQHCs should continue to follow their FI's instructions for HCPCS coding of service. No replacement code.

b - FQHC Preventive Laboratory Procedure

Cholesterol screening, stool testing, dipstick urinalysis, and thyroid function test (HCPCS code 89399 until December 31, 2003).

NOTE: *HCPCS code 89399 is reported only if the FQHC actually performs the laboratory test. When the FQHC draws the specimen but orders the test to be done in an*

independent lab, this code should not be reported. In addition, you must use this code only when done in conjunction with a face-to-face encounter during the same visit. This code is discontinued after December 31, 2003.

c - FQHC Preventive Medicine Intervention

Counseling and risk identification without the physical exam; additional counseling. Independent FQHCs should continue to follow their FI's instructions for HCPCS coding of service. No replacement code.

d - FQHC Acute Care Visit

No preventive services rendered (HCPCS code 99212).

e - Immunizations

(HCPCS code 90749).

See sections 120 and 130 below for information on billing preventive or lab services, applicable to RHCs/FQHCs as specified therein.

Billing requirements claim forms/formats do not allow for more than one HCPCS code to be reported per line item. Therefore, in situations where an independent FQHC provides more than one preventive service during the course of a visit, and these services are billed under different HCPCS codes listed above, the independent FQHC must report separate lines for the clinic visit revenue code (0520) for each preventive service provided to show each HCPCS code. All but the first line item for that date is billed with a 0 in the units and total charges field. The first line item for the visit is billed with units equaling 1, representing the single encounter that day, and usual total charges are reported for the encounter on that line. The FQHC must report only 1 unit per visit regardless of the number of preventive services provided during a visit.

In addition, in situations where the independent FQHC provides more than one of the preventive services in a specific grouping under a single HCPCS during the course of a visit, the independent FQHC must report the appropriate HCPCS code for that group only once. For example, if the independent FQHC provides a dipstick urinalysis and a thyroid function test during the same visit, AND those are the only services provided in the encounter, a single line item would be billed with only 1 unit.

When independent FQHCs provide immunizations, they report HCPCS code 90749 only when the immunization(s) is given in conjunction with another service during a particular visit. If the sole purpose of the visit is to obtain an immunization, HCPCS code 90749 is not reported since a visit is not billed if this is the only service the FQHC provides.

Where an independent FQHC does not provide any preventive service during the course of a visit, the FQHC must report HCPCS code 99212 (no preventive service rendered).

Therefore, every claim from an independent FQHC must contain at least one of the HCPCS codes described above.

110.2 - Reporting of Specific HCPCS Codes for Hospital-based FQHCs

(Rev. 371, Issued 11-19-04, Effective: 04-01-05, Implementation: 04-04-05)

A. Claims with Dates of Service on or After April 1, 2005

Effective April 1, 2005, hospital-based FQHCs are no longer required to report any specific HCPCS codes when billing for FQHC services.

B. Claims with Dates of Service Before April 1, 2005

For claims submitted by hospital-based FQHCs with dates of service before April 1, 2005, Medicare instructions for billing to FIs required HCPCS code reporting for specific services in the following HCPCS ranges:

99201-99205, 99211-99215, as appropriate.

Similar requirements were never developed for other types of provider-based FQHCs.

120 – General Billing Requirements for Preventive Services

(Rev. 371, Issued 11-19-04, Effective: 04-01-05, Implementation: 04-04-05)

Professional components of preventive services are part of the overall encounter, and for TOBs 71x/73x, have always been billed on lines with revenue code 052x. In addition to previous requirements for independent FQHCs exclusively, all RHCs/FQHCs had been required to report HCPCS codes for certain preventive services subject to frequency limits.

*Detailed billing instructions for preventive benefits and vaccines are found in chapter 18 of this manual (*http://www.cms.hhs.gov/manuals/104_claims/clm104c18.pdf*).*

Physician or base-provider claims would reflect these services under specific HCPCS codes.

RHCs/FQHCs do not receive any reimbursement on TOBs 71x/73x for technical components of such services. The associated technical components are billed on other types of claims that are subject to strict editing to enforce statutory frequency limits. Therefore, CMS concluded that the enforcement of the frequency limits was accomplished for RHCs/FQHCs via the technical components of the services they do not bill themselves, and no specific data had to be provided on TOBs 71x and 73x to further enforce these statutory limits. Therefore, as of April 1, 2005, RHCs and FQHCs do not have to report HCPCS codes associated with preventive services subject to frequency limits on any line items billed on TOBs 71x/73x.

Though most preventive services have HCPCS codes that allow separate billing of professional and technical components, mammography and prostate PSA do not. However, RHCs/FQHCs still must provide the professional component of these services since they are in the scope of the RHC/FQHC benefit. Such encounters are billed on line items using revenue code 052x and no HCPCS coding (dates of service April 1, 2005 and after).

For vaccines, RHCs/FQHCs do not separately report for influenza virus or pneumococcal pneumonia *vaccines on the 71x/73x claims.* Costs for the influenza virus or pneumococcal pneumonia *vaccines are* included in the cost report and *no line items billed are billed in addition to the encounter. Hepatitis vaccine is also reimbursed through the cost report, though it is not paid at the same 100% rate as the other 2 vaccines. Therefore, no line items specifically for this service are billed on RHC/FQHC claims in addition to the encounter. An encounter can not be billed if the vaccine administration is the only service the FQHC provides.*

130 - Laboratory Services

(Rev. 1, 10-01-03)

PM A-99-8

The RHCs must furnish the following lab services to be approved as an RHC. However, these and other lab services that may be furnished are not included in the encounter rate and must be billed separately.

- Chemical examinations of urine by stick or tablet method or both;
- Hemoglobin or hematocrit;
- Blood sugar;
- Examination of stool specimens for occult blood;
- Pregnancy tests; and
- Primary culturing for transmittal to a certified laboratory (No CPT code available).

Effective January 1, 2001, independent RHCs/FQHCs bill all laboratory services to the carrier, and provider based RHCs/FQHCS bill all lab tests to the FI under the host provider's bill type. In either case payment is made under the fee schedule. HCPCS codes are required for lab services.

Refer to Chapter 16 for general billing instructions.

Refer to §40.4 for lab services included in the all-inclusive rate.

140 - FI/Carrier Coordination

(Rev. 1, 10-01-03)

B3-9204.D

140.1 - FI Responsibility for Notifying Carrier

(Rev. 1, 10-01-03)

B3-9204.D

Physicians associated with an RHC/FQHC may provide some services that are paid by the FI and some services that are paid by the carrier.

Within 60 days of certification of the RHC, the FI must send the carrier servicing the area in which the RHC is located, and also the RRB carrier the following information:

1. The names of all physicians associated with the clinic, their relationships with the clinic, and the address of any place other than the clinic where the physician renders services;

2. A copy of any written compensation agreement between the physician and the clinic; and

3. The names of **all** RHC physicians who must also provide coverage at the emergency room of hospitals at which they have staff privileges;

The FI will provide updates for accretions or deletions to the above information within 45 days of the occurrence.

140.2 - Special Carrier Actions Relating to RHCs/FQHCs

(Rev. 1, 10-01-03)

B3-9204

The carrier, upon receipt of the notification that an independent RHC or FQHC has been approved, will contact the clinic and the associated physicians to determine if the RHC/FQHC will provide services that are covered by the program but not included in the definition of RHC/FQHC services. The carrier will instruct the RHC/FQHC and associated physician on the billing procedures for non-RHC/FQHC services.

Carriers should be aware that certain items and services furnished by clinics might be covered under the Medicare program but are not included in the definition of RHC or FQHC services. These services are listed in the Medicare Benefit Policy Manual, Chapter 13. The provider of these services should bill the carrier. Provider based RHCs/FQHCs

will bill the FI. Carrier payment depends upon the usual carrier payment rules for the service, e.g., fee schedule.

The carrier also must edit claims to assure that it pays only for the non-RHC/FQHC services provided. Carriers should return inappropriate RHC/FQHC claims to the provider with a message to bill the FI.

200 - Agreements Between CMS and RHC/FQHC

(Rev. 1, 10-01-03)

RHC-310

200.1 - General

(Rev. 1, 10-01-03)

RHC-310

A - CMS enters into an agreement with a rural health clinic (RHC) or federally qualified health center (FQHC) that wishes to participate in the Medicare program.

1. RHCs - If a clinic is certified as an RHC, it receives a notice to that effect from CMS and two copies of the agreement.

2. FQHCs - The Public Health Service (PHS) recommends to CMS those entities that meet the requirements of §§329, 330, and 340 of the PHS Act and wish to participate in Medicare as FQHCs. The entity must then seek approval from CMS by signing an agreement (i.e., an attestation statement) similar to the agreement signed by RHCs. The center receives a notice regarding approval of FQHC status from CMS and two copies of the agreement.

3. The following instructions are applicable both to RHCs and FQHCs. The RHC/FQHC must:

    - Have both copies of the agreement signed by an authorized representative of the clinic or center (e.g., the director, supervising physician, or some other individual empowered to sign binding agreements on behalf of the clinic or center); and

    - Return (file) both copies to the responsible CMS office or official as is specified in the instructions accompanying the agreement.

B - If CMS accepts the agreement filed by the clinic or center, it signs both copies of the agreement on behalf of the Secretary and returns one copy to the clinic or center along with a notice of acceptance and the date on which the agreement is effective.

NOTE: FQHC regulations were published on June 12, 1992. CMS mailed copies of the FQHC agreement (attestation statement) to entities qualified for FQHC status, including all entities approved by the PHS under §§329, 330, and 340 of the PHS Act and federally funded health centers.

OBRA 1993 added a new program to the definition of FQHCs. An outpatient health program or facility operated by a tribe or tribal organization under the Indian Self-Determination Act or by an urban Indian organization receiving funds under title V of the Indian Health Care Improvement Act are considered FQHCs as of October 1, 1991.

FQHCs are required to meet all Federal requirements as of the date they select to begin furnishing services to Medicare beneficiaries.

After August 11, 1992, FQHCs, except those facilities approved under the Indian Self-Determination Act or the Indian Health Care Improvement Act, cannot submit agreements seeking to qualify to provide FQHC services for periods prior to the date of submission.

200.2 - Duration of RHC/FQHC Agreement

(Rev. 1, 10-01-03)

RHC-311

Agreements between RHCs/FQHCs and CMS are generally for a term of one year. They may be annually renewed by mutual agreement of the RHC/FQHC and CMS. A new agreement need not be signed each year. Special circumstances may result in a term of less than one year for an initial agreement, e.g., a clinic or center may wish the agreement year to run concurrently with the RHC/FQHC's fiscal year or have some other technical considerations. If CMS refuses to renew an agreement, the RHC/FQHC may appeal as explained in §200.3.

If the RHC/FQHC wishes to terminate the agreement during the term of the agreement, see §220. If CMS terminates the agreement during the term of the agreement, see §220.2.

200.3 - Appeals by Entities With Respect to Agreements (Certification)

(Rev. 1, 10-01-03)

RHC-313

A - Appeals Regarding Failure to Certify or CMS Refusal to Enter Into or Renew an Agreement

A clinic or center may appeal CMS's decision in accordance with the provisions of 42 CFR Part 498, if CMS makes a determination with respect to the following matters:

- Whether a clinic or center meets the appropriate conditions for approval;
- Whether a non-grantee center meets the requirements under the PHS law and the appropriate conditions for approval;
- Whether a prospective RHC/FQHC qualifies as a supplier; or
- Whether a supplier continues to meet the appropriate conditions for approval.

B - Filing Appeals

A clinic or center dissatisfied with one of the above determinations may file a request for hearing with the Associate Regional Administrator, Divisions of Medicaid and State Operations/Divisions of Health Standards and Quality. The RO provides a description of the procedure to be followed and the necessary forms and other requirements for filing such an appeal.

210 - Content and Terms of Agreements

(Rev. 1, 10-01-03)

RHC-320

In the agreement/attestation statement signed by an RHC or FQHC, the clinic or center agrees to maintain its compliance with all of the conditions for certification/coverage in 42 CFR Part 491. If a clinic/center fails to maintain compliance with one or more of the conditions, it must promptly report this (usually within 30 days of the failure) to the responsible CMS office or official. Failure to report promptly may be a cause for termination of the clinic/center's agreement.

210.1 - Charges to Beneficiaries

(Rev. 1, 10-01-03)

RHC-321

In the agreement/attestation statement signed by the RHC or FQHC, the clinic or center agrees not to charge Medicare beneficiaries (or any other person acting on a beneficiary's behalf) for any RHC/FQHC service for which Medicare beneficiaries are entitled to have payment made on their behalf by the Medicare program. This includes

- Deductible (as prescribed in §50)
- Coinsurance (as prescribed in §50)
- Items or services for which the beneficiary would have been entitled to have payment made had the RHC or FQHC filed a request for payment. The amount of Medicare payment to an FQHC is unaffected by its waiver of the Part B

coinsurance for those beneficiaries with incomes up to 200 percent of the poverty level in accordance with the requirements of the PHS sliding fee scale. (See the PHS "Program Expectations for Community and Migrant Health Centers.").

- The clinic or center may charge the beneficiary for items and services which are not Medicare covered services.

210.2 - Refunds to Beneficiaries

(Rev. 1, 10-01-03)

RHC-322

A - Money Incorrectly Collected

The agreement between CMS and the RHC or FQHC, the clinic/center agrees to refund as promptly as possible any money incorrectly collected from Medicare beneficiaries or from someone on their behalf.

B - Definition of Money Incorrectly Collected

Money incorrectly collected means any amount for covered services that is greater than the amount for which the beneficiary was liable because of the deductible (except for FQHC services) and coinsurance requirements.

Amounts are considered to have been incorrectly collected because the clinic or center believed the beneficiary was not entitled to Medicare benefits but:

- The beneficiary was later determined to have been entitled to Medicare benefits;
- The beneficiary's entitlement period fell within the time the clinic or center's agreement with CMS was in effect; and
- Such amounts exceed the beneficiary's deductible (except for FQHC services) and coinsurance liability.

210.3 - Treatment of Beneficiaries

(Rev. 1, 10-01-03)

RHC-323

In the agreement between CMS and the RHC or FQHC, the clinic or center agrees to accept Medicare beneficiaries for care and treatment. The clinic or center cannot impose any limitations with respect to care and treatment of Medicare beneficiaries that it does not also impose on all other persons seeking care and treatment from the RHC or FQHC. If the RHC or FQHC does not furnish treatment for certain illnesses and conditions to patients who are not Medicare beneficiaries, it need not furnish such treatment to

Medicare beneficiaries in order to participate in the Medicare program. It may not, however, refuse to furnish treatment for certain illnesses or conditions to Medicare beneficiaries if it furnishes such treatment to others. Failure to abide by this rule is a cause for termination of the clinic or center's agreement to participate in the Medicare program.

220 - Termination of Agreement

(Rev. 1, 10-01-03)

RHC-330

220.1 - Termination of Agreement by Clinic or Center

(Rev. 1, 10-01-03)

RHC-330

A - General Rule

An RHC or FQHC that wishes to terminate its agreement to participate in the Medicare program may do so by:

1. Filing with CMS a written notice stating its intention to terminate its agreement; and

2. Informing CMS of the date upon which it wishes the termination to take effect.

B - Effective Date

Upon receiving the clinic or center's notice of its intention to terminate the agreement, CMS will set a date upon which the termination will take effect. This effective date may be:

- The date proposed by the clinic or center in its notice of intention to terminate the agreement; or

- A date set by CMS, which can be no later than six months after the date the clinic or center's notice of intention to terminate was received.

The effective date of termination may be less than six months following CMS's receipt of the clinic or center's notice of its intention to terminate if CMS determines that termination on that date would not:

- Unduly disrupt the furnishing of RHC/FQHC services to the community serviced by the clinic or center; or

- Otherwise interfere with the effective and efficient administration of the Medicare program.

C - Voluntary Termination Without Notice of Intent

An RHC or FQHC is considered to have voluntarily terminated its agreement if it ceases to furnish RHC or FQHC services to the community. The termination is effective after the last day of business of the clinic or center.

220.2 - Termination by CMS

(Rev. 1, 10-01-03)

RHC-331

A - General Rule

The CMS may terminate an agreement with an RHC or FQHC if it finds that the clinic or center:

- No longer qualifies as a supplier; or
- Is not in substantial compliance with:
    - The provisions to the agreement;
    - The requirements of 42 CFR Part 405, Subpart X and Part 491;
    - Any other applicable Medicare regulations in 42 CFR; or
    - Any other applicable provisions of title XVIII of the Act.

B - Notice by CMS

The CMS will notify the RHC or FQHC in writing of its intention to terminate the agreement at least 15 days before the effective date stated in the written notice.

C - Clinic or Center Appeal

An RHC or an FQHC may request an appeal of CMS's decision to terminate the agreement in accordance with the provisions of 42 CFR Part 498.

D - Change of Ownership

When an RHC or FQHC undergoes a change of ownership, the agreement with the existing clinic or center is automatically assigned to the new owner so that there is no interruption in service. However, a new agreement with updated information must subsequently be signed. Only if the clinic or center, under the change of ownership,

meets the applicable requirements for approval can the agreement be executed. For FQHCs, these requirements include PHS approval.

An RHC or FQHC that plans to change ownership must give advance notice of its intention so that a new agreement can be negotiated or so that the public may be given sufficient notice in the event that the new owners do not wish to participate in the Medicare program. A clinic or center that plans to enter into a lease arrangement (in whole or in part) should also give advance notice of its intention.

A change of ownership occurs, for example, when:

- A sole proprietor transfers title and property to another party (applicable only to RHCs);
- In the case of a partnership, there is an addition, removal, or substitution of a partner;
- An incorporated RHC or FQHC merges with an incorporated entity, which is approved by the program, and the nonapproved entity is the surviving corporation. It also occurs when two or more corporate clinics or centers consolidate and the consolidation results in the creation of a new corporate entity;
- An unincorporated RHC (a sole proprietorship or partnership) becomes incorporated; or
- The lease of all or part of an entity constitutes a change of ownership of the leased portion.

220.3 - Effect of Termination

(Rev. 1, 10-01-03)

RHC-332

When an RHC or FQHC agreement is terminated, whether by the entity or by CMS, no payment is available to the RHC or FQHC for services it furnishes to Medicare beneficiaries on or after the effective date of the termination.

220.4 - Notice to the Public

(Rev. 1, 10-01-03)

RHC-333

Public notice of both the effective date and the effect of termination of an RHC or FQHC agreement is made 15 days before the effective date of the termination in at least one newspaper of general circulation in the area serviced by the clinic or center. This notice must be given by:

- The clinic or center if it has voluntarily terminated the agreement, and CMS has approved the termination and set an effective date for the termination; and

- CMS when it has terminated the agreement.

220.5 - Conditions for Reinstatement of Clinic or Center Terminated by CMS

(Rev. 1, 10-01-03)

RHC-334

When an agreement with an RHC or FQHC has been terminated by CMS, CMS does not enter into another agreement with the clinic or center to participate in the Medicare program unless CMS:

- Finds that the reason for the termination no longer exists; and

- Is assured that the reason for termination of the prior agreement will not recur.